DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/27/12

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote dignity and individuality during meal service in the dining room for twelve residents in one of two dining areas. The findings included: Observation on September 10, 2012, from 12:17 p.m., through 1:10 p.m., in the second floor dayroom, revealed the residents' meals were not served upon arrival. Twelve residents were present at the time of the observation. The trays were not served as soon as they arrived on the floor at 12:25 p.m. Three Certified Nursing Assistants (CNA) and one Licensed Practical Nurse (LPN) were assisting residents with tray set-up and feeding, both in the dayroom/dining room and on the second floor halls. One resident in the dining room (#57) had a family member present to feed the resident the noon meal. The family member retrieved the tray as soon as it arrived on the floor, assisted the resident with a clothing protector, borrowed a chair from the nursing station, and fed the resident lunch. Eleven residents in the room were awaiting their meals while resident #57 ate. Continued observation revealed the time interval	F 241	F241 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No negative outcomes were noted thru observation. More tables were placed in the dinning room on 9/10/12 by maintenance. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Potential affected resident will be identified thru observation. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Unit Managers will monitor meal services daily for two weeks and then weekly for four weeks and then PRN to ensure correct dinning procedures and resident dignity during dinning are being followed. The DON/ADON, Unit Manager, MDS Nurse, or Night Supervisor will educate the nursing staff on correct dinning procedures and resident dignity during dinning by 9/28/2012. Starting after 9/28/12 staff will be in serviced on the process for meal services to ensure meals are served timely prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher A Gadaly	Administrator	9/24/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 between the first resident (#57) receiving their meal tray from the family and the second resident (#25) receiving a tray from a staff member was twelve minutes. Another eight minutes elapsed before the third and fourth residents (#'s 135 and 39), seated at the same table with resident #25, were served their meals and assisted by staff with tray set-up. One resident (#94) waited for other residents to finish their meal for a bedside table to become available. This resident waited 40 minutes after the trays arrived on the floor to begin eating. Resident #94 stated " ...I'm hungry ..." as other residents seated around the resident ate. Interview with LPN #3 at the time of the observation confirmed the residents waited for their meals and watched as other residents ate.	F 241	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** DON/ADON or Quality Nurse will report audit findings to the Quality Assurance Committee on a monthly basis for six months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review and interview the facility failed to ensure personal choices were honored for one resident (#84) of thirty-four residents reviewed. The findings included:	F 242	F 242 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #84 was educated by the MDS nurse on the visitation policy and resident rights on 9/18/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Starting on 9/24/12 during 72 hour meeting and all other care plan meetings the team will discuss the visitation policy with families and residents to identify if the visitation policy has been accommodated by the staff.	

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F 242	Continued From page 2 Resident #84 was admitted to the facility on April 28, 2012, with diagnoses including Cellulitis of Toe, Depressive Disorder, Failure to Thrive, Diabetes Mellitus, Hyperglycemia, History of Urinary Tract Infections and Suicidal Ideation. Review of facility policy entitled Access and Visitation revealed..."You have the right to immediate access to any...family members and other relatives"... Interview with resident #84 on September 11, 2012, at 10:22 a.m., in resident's room revealed there had been an incident approximately three months ago when the resident's niece came to visit with two children at 8:15 p.m., and the resident became upset when her niece and family were asked to leave by Licensed Practical Nurse (LPN) #4. Further interview revealed the resident told LPN #4 the family had come a long way to visit and rarely could visit. Interview with the Director of Nursing (DON) on September 12, 2012, at 9:50 a.m., in the DON office revealed the DON was unaware of the incident. Telephone interview on September 12, 2012, at 12:30 p.m., with LPN # 4 revealed the LPN had asked the family to leave because they had arrived after the posted visiting hours. LPN #4 stated the resident became upset and the LPN requested the family leave twice; once when they first arrived, and again ten minutes later. Interview with the DON on September 12, 2012, at 12:35 p.m. confirmed the facility had failed to	F 242	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Any visitation issues identified in the care plan meeting the Social Services Director will complete a grievance form and start the grievance procedure. The DON/ADON, Unit Managers, MDS Nurse, or Night Supervisor will educate all staff on resident rights and the visitation policy by 9/28/2012. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The Social Services Director will report any visitation grievances to the QA committee monthly for 3 months and PRN. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completed 10/22/12

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F 242	Continued From page 3 honor the resident's personal choices regarding visitors.			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure the call light was within reach for one resident (#114) of thirty-four residents reviewed. The findings included: Resident #114 was admitted to the facility on August 27, 2012, with diagnoses including Folliculitis, Weakness, Congestive Heart Failure, Depression, Fluid Retention, Hypertension, Diabetes Mellitus, Arthralgia, Gastroesophageal Reflux Disease, Vitamin D Deficiency, Dementia, Fever, Pain, and Hypoalbuminemia. Medical record review of five day Minimum Data Set (MDS) dated April 5, 2012 revealed a Brief Interview for Mental Status (BIMS) score of 4, inidicating severe cognitive impairment, and required a two person assist with transfers. Interview with the resident on September 10,	F 246	F246 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Call light was immediately placed in resident's reach. Resident was educated on the use of call bell. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident have the potential to be affected. 100% check of call lights will be completed by nursing and maintenance to ensure call lights are in reach and functioning on 9/21/12. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Unit Managers will make daily rounds to ensure call bells are in reach. The nursing staff will be educated by the DON/ADON, Unit Managers, MDS Nurse, or Night Supervisor on call bell placement and response by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

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F 246	Continued From page 4 2012, at 2:20 p.m., in the resident's room revealed an awareness of what the call light was for and how to use it. Observation of resident #114 on September 10, 2012, at 2:39 p.m., in the resident's room revealed the call light hanging over the back of the bed behind the mattress. Interview with the resident on September 10, 2012 at 2:40 p.m., in resident's room revealed the resident was unable to reach the call light when prompted. Observation of the resident on September 11, 2012 at 8:30 a.m., in the resident's room revealed the call light hanging over the back of the bed behind the mattress. Interview with Licensed Practical Nurse (LPN) #2 on September 11, 2012, at 8:40 a.m., in the resident's room confirmed the call light was out of reach of the resident.	F 246	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report round findings to the Quality Assurance Committee monthly. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272		

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F 272	Continued From page 5 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess the dental status of one resident (#114) of thirty-four residents reviewed in Stage 2. The findings included: Resident # 114 was readmitted to the facility on July 31, 2012, with diagnoses including Diabetes Mellitus, Depression, and Alzheimer's Disease.	F 272	F272 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 114 had dental assessment and care plan updated by the ADON on 9/19/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident have the potential to be affected. 100% record review by Nursing Administration of dental assessments will be completed by 10/8/12 to ensure all assessments are current and accurate with care plan updated. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON or Unit Managers will make weekly audits of dental assessment on new admission and re- admissions to ensure the assessments are completed correctly. The DON/ADON, Unit Managers, MDS Nurse, or Night Supervisor will in-service licensed staff on dental assessments to be completed by 9/28/12. CNAs will be educated by t he DON/ADON, Unit Managers, MDS Nurse, or Night Supervisor on communicating to the nurse with any and all resident concerns including dental concerns by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

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F 272	Continued From page 6 Medical record review of an admission assessment dated July 31, 2012, revealed the dental/oral health portion of the assessment indicated the resident had teeth and no dental issues. The resident was transferred to the hospital on August 4, 2012, due to hypoglycemia and syncope. The resident was hospitalized and was transferred back to the facility on August 10, 2012. Medical record review of the August 10, 2012, admission assessment indicated the resident was edentulous (no teeth) and had dentures. Medical record review of a Nurse Practitioner's (NP) Daily Progress note, dated August 30, 2012, revealed the resident had difficulty with food textures and chewing. The NP changed the resident's prescribed diet from mechanical soft to pureed. Interview with Certified Nursing Assistant (CNA) #1 on September 12, at 3:05 p.m. revealed the CNA was regularly assigned to care for the resident, both before and following the August 4, 2012, hospitalization. The CNA stated the resident had dentures and the CNA assisted the resident with denture care and feeding daily. The CNA stated the resident had complained of difficulty chewing since her return from the hospital on August 10th but the CNA did not remember the resident having dentures in the mouth since the resident's readmission to the facility on August 10, 2012. Interview with the Director of Nursing (DON) on September 12, 2012, at 2:10 p.m., in the conference room, confirmed the admission	F 272	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completed 10/20/12

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F 272	Continued From page 7 assessments were conflicting and the resident did have dental issues that the facility failed to accurately identify on the assessment.		F279 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 4 had care plan updated on 9/18/12 by the Activities Director. Residents # 84, and # 32 had care plans updated by the MDS nurse on 9/13/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident have the potential to be affected. 100% review of resident care plans by DON/ADON, MDS Nurses, and Unit Managers will be done by 10/23/12 to ensure care plans are up to date. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON will audit 5 charts/week x 6 weeks then 2 charts/week x 6 weeks then randomly to ensure care plans are up to date. Licensed nurses, MDS nurses, and Care Plan team will be educated by the DON/ADON on revising a care plan when changes occur by 9/28/12. MDS nurses and Care Plan team will be educated by the DON/ADON on identifying and addressing pain management and activities on the care plan by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to revise the care plan to for three residents (#4, #84, and #32) of thirty-four sampled residents in stage 2. The findings included: Resident #4 was admitted to the facility on April			

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F 279	Continued From page 8 23, 2012, with diagnosis including Congestive Heart Failure, Hypertension, Failure to Thrive, and Muscle Weakness. Medical Record review of an activity evaluation completed on April 23, 2012, revealed "I usually don't like to do anything not really social" Continued record review of the current resident care plan updated July 19, 2012, revealed no documentation to reflect specific goals and interventions to address activities. Interview with the facility Minimum Data Set (MDS) coordinator on September 12, 2012, at 10: 21 a.m., in the MDS office confirmed the resident's care plan did not address activities. Resident #84 was admitted to the facility on April 28, 2012, with diagnoses including Cellulitis of Toe, Depressive Disorder, Failure to Thrive, Diabetes Mellitus, Hyperglycemia, History of Urinary Tract Infections and Suicidal Ideation. Medical record review of Minimum Data Set (MDS) quarterly review dated July 15, 2012, revealed pain was listed as frequent, but not constant. Medical record review of care plan dated July 19, 2012, did not reveal pain management as a problem. Interview with the MDS coordinator on September 12, 2012 at 1:00 p.m., in the MDS office confirmed the facility failed to develop a comprehensive plan of care including addressing pain management. Resident #32 was admitted to the facility on May 23, 2006, with diagnoses including	F 279	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12

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F 279	Continued From page 9 Gastrointestinal Hemorrhage, Diabetes, Chronic Airway Obstruction, Vascular Dementia, and Hypertension. Medical record review of the quarterly Minimum Data Set dated June 10, 2012, revealed the resident was able to make needs known, and understood what was said. Medical record review of the Care Plan dated September 6, 2012, revealed no documentation to indicate the resident had dentures or the care of the dentures.. Observation and interview on September 11, 2012, at 9:06 a.m., revealed the resident seated in a wheelchair in the dining room, and stated the dentures were too loose, "they worry me all the time," and would like to see a dentist. Interview on September 12, 2012, at 1:55 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the Care Plan dated September 6, 2012, did not address the care of the resident's dentures.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280	F280 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 50 had care plan updated by the MDS nurse on 9/13/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident with behaviors have the potential to be affected. 100% review of resident care plans with behaviors by DON/ADON, MDS Nurses, and Unit Managers will be done by 10/23/12 to ensure care plans are up to date.	

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	445498	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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F 280	Continued From page 10 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to revise a care plan for one (#50) resident of thirty-four sampled residents in stage 2. The findings included: Resident #50 was admitted to the facility on June 6, 2012, with diagnoses including Mental Disorder, Hypertension, Congestive Heart Failure, and Osteoporosis. Medical record review of the Quarterly Minimum Data Set (MDS) dated August 26, 2012, revealed the resident had physical behavior symptoms directed toward others. Medical record review of the care plan dated August 30, 2012, revealed no update to reflect the resident's behaviors. Interview on September 12, 2012, at 10:30 a.m., with Registered Nurse #1, in the MDS office, confirmed the care plan had not been updated to	F 280	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON will audit 5 charts/week x 6 weeks then 2 charts/week x 6 weeks then randomly to ensure behavior care plans are up to date. Licensed nurses and MDS nurses will be educated by the DON/ADON, or Night Supervisor on revising a care plan when behaviors occur by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12

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F 280	Continued From page 11 reflect the resident's behaviors.			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop an Interim Care Plan to address the risk for falls and pain for one resident (#135) of thirty-four residents reviewed in Stage 2. The findings included: Resident #135 was admitted to the facility on August 31, 2012, with diagnoses including Fall with Right Hip Injury, Bilateral Leg Pain, History of Deep Venous Thrombosis, Hypertension, and Urinary Tract Infection. Medical record review of the Fall Risk Evaluation dated August 31, 2012, revealed the resident was at risk for falls. Medical record review of the nursing notes dated September 9, 2012, at 1:00 p.m., revealed the resident experienced a fall without injury. Observation on September 10, 2012, at 11:02 a.m., revealed the resident seated in a wheelchair, in the dining room, and complained of pain in the legs. Medical record review of the Interim Plan of Care	F 281	F281 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 135 had care plan updated by the MDS nurse on 9/13/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All new and returning residents have the potential to be affected. 100% review of all residents with interim care plans will be done by DON/ADON, MDS Nurses, and Unit Managers to ensure they are up to date by 10/15/12. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON will audit 5 charts/week x 6 weeks then 2 charts/week x 6 weeks then randomly to ensure interim care plans are up to date. Licensed nurses and MDS nurses will be educated by the DON/ADON or Night Supervisor on updating a care plan for any resident that has a fall by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

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F 281	Continued From page 12 dated August 31, 2012, revealed no interventions to address the resident's risk for falls or pain. Interview on September 11, 2012, at 9:25 a.m., with Registered Nurse #1, in the conference room, confirmed the resident's Interim Plan of Care did not address the resident's risk for falls or pain.	F 281	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure current physician's orders for the administration of sliding scale insulin for one resident (#51), and failed to ensure proper positioning for two residents (#135, #132) of thirty-four residents reviewed in Stage 2. The findings included: Resident #51 was admitted to the facility on October 13, 2006, with diagnoses including Diabetes and Schizophrenia. Observation on September 11, 2012, at 5:08 p.m, revealed Licensed Practical Nurse (LPN) #2 checked resident #51's blood sugar, with a result	F 309	F309 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 51 had an order obtain to continue sliding scale on 9/11/12. Resident # 135 was fitted for a wheel chair and cushion placed on 9/10/12. Resident # 132 had bed replaced with an electric bed on 9/12/12.	

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F 309	Continued From page 13 of 179. Interview on September 11, 2012, at 5:10 p.m., with LPN #2 revealed the resident was to receive Humalog insulin 2 units per sliding scale related to the blood sugar of 179, in addition to Humalog 10 units ordered to be administered with meals. Medical record review of the September 2012, physician's recapitulation orders revealed the resident was to receive Humalog insulin 10 units subcutaneously (by injection) with meals. Continued review of the September 2012, physician's recapitulation orders revealed no orders for the resident to receive sliding scale insulin. Medical record review of a Subcutaneous Sliding Scale Insulin Order Set, signed by the physician on March 26, 2012, revealed the resident was to have the blood glucose checked before meals and at hour of sleep, and if the blood sugar was 151 - 200 the resident was to receive 2 units of Humalog insulin. Observation on September 11, 2012, at 6:35 p.m., revealed LPN #2 administered Humalog 12 units subcutaneously into the resident's right arm. Interview on September 12, 2012, at 7:30 a.m., with the Director of Nursing confirmed there was no current physician's order to administer sliding scale insulin to the resident at the time of the observation on September 11, 2012. Resident #135 was admitted to the facility on August 31, 2012, with diagnoses including Fall with Right Hip Injury, Bilateral Leg Pain, History of	F 309	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** 100 % review of physician recapitulation orders for September will be done by the DON/ADON, and Unit Managers to ensure orders are correct by 9/30/12. 100% review of all residents for positioning will be done by the DON/ADON, Restorative nursing, and Therapy by 9/30/12. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON will audit 5 charts/week x 6 weeks then 2 charts/week x 6 weeks then randomly to ensure physician recapitulation orders are correct. Starting on 9/24/12 the Unit Managers will make rounds to ensure correct positioning for residents in the chair or bed. Licensed nurses will be educated by the DON/ADON, Unit Managers, MDS nurse, or Night Supervisor on checking physician recapitulation orders to ensure all orders have been carried forward by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

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F 309	Continued From page 14 Deep Venous Thrombosis, Hypertension, and Urinary Tract Infection. Observation on September 10, 2012, at 2:20 p.m., revealed the resident seated in a wheelchair without a cushion in the seat of the wheelchair. Continued observation revealed the resident's right leg was internally rotated and there were no foot or leg rests located on the wheelchair. Observation and interview with the resident on September 10, 2012, at 2:25 p.m., in the dining room, revealed the resident's right leg and bottom felt uncomfortable. Observation and interview on September 10, 2012, at 2:30 p.m., with Licensed Practical Nurse (LPN) #1, confirmed there were no leg rests or foot rests on the resident's wheelchair, and there was no cushion in the seat of the wheelchair. Observation on September 10, 2012, at 2:40 p.m., revealed the therapy department staff, removed the resident to the therapy department to evaluate the resident for a different wheelchair/positioning. Medical record review of a Physical Therapy progress note dated September 10, 2012, revealed "...PT (Physical Therapy) fitted pt. (patient) for a proper fitting w/c..." Interview on September 12, 2012, at 8:40 a.m., with Physical Therapist #1, in the conference room, revealed the Physical Therapist had evaluated the resident for a proper fitting wheelchair on September 10, 2012. Continued interview revealed the resident needed a taller	F 309	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12

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F 309	Continued From page 15 wheelchair with a longer seat due to the resident's height, and a leg rest to the right side and a seat cushion. Continued interview confirmed the resident was not positioned properly at the time of the observation on September 10, 2012, at 2:30 p.m. Resident #132 was admitted to the facility August 24, 2012, after a fall at home, with diagnoses including Aftercare Traumatic Left Hip Fracture, History of Left Sided Weakness and Childhood Polio. Medical record review of the Minimum Data Set (MDS) revealed the resident was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15/15, required two persons' assistance with transfers, and one person's assistance with bathing and dressing. Medical record review of the Social Services Admission Assessment dated August 24, 2012, revealed the resident had lived independently at home prior to the fall and hospitalization to repair the fractured left hip. Observations in the resident's room on September 10, 11, and 12, 2012, revealed the resident resting supine in bed. When asked if comfortable and able to sit up, the resident stated, "It's a crank bed (manual crank) and I have to call for help to raise the head of the bed." Interview with the Unit Manager on September 12, 2012, at 12:15 p.m., in the Hallway, confirmed the resident was not able to raise the head of the bed independently to sit up in bed and required an electric bed.	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 16 HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, review of the Material Safety Data Sheets, and interview, the facility failed to safely store chemicals in the facility beauty shop.

The findings included:

Observation on September 10, 2012, at 10:53 a.m., revealed the door to the beauty shop was open and unattended. Continued observation revealed the following items were located on the counter in the beauty shop: a one pound 2 ounce can of glass cleaner, approximately 1/2 full; a seven ounce bottle of Selsun Blue shampoo, approximately 3/4 full; a sixty-four ounce bottle of raspberry almond shampoo, approximately 1/4 full; a container with approximately eight ounces of barbicide disinfectant; and a hair clipper plugged into an electrical outlet. Continued observation revealed there were no residents in the hallway adjacent to the beauty shop.

Review of the Material Safety Data Sheet (MSDS) for the glass cleaner revealed "...Effects of Overexposure - Conditions to Avoid: May cause

F323

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

No residents were affected.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All residents had the potential to be affected.

Beauty shop was locked and the beautician in serviced.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.

Starting on 9/24/12 the CEO will check the beauty shop daily and PRN to ensure it is locked and chemicals are placed away.

On 9/10/12 the beautician was educated by the CEO on not leaving the beauty shop unlocked and unattended and keeping chemicals and items placed away.

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F 323	Continued From page 17 mild eye irritation. May be harmful if swallowed. Inhalation of product mist may cause respiratory irritation. Avoid contact with eyes. Avoid prolonged or repeated contact with skin. Do not swallow. Avoid breathing product mist. Wash thoroughly after handling. Conditions Aggravated by Use: Use of this product may aggravate preexisting skin, eye and respiratory disorders including asthma and dermatitis...Handling & Storage: Keep out of reach of children..." Review of the MSDS for Selsun Blue Medicated Treatment Shampoo revealed "...This product is used for the treatment of dandruff. It is an eye irritant and prolonged skin contact may produce burns, irritation, and dermatitis. It may cause sensitivity reactions. Ingestion of large amounts may cause gastrointestinal upset...First Aid Measures - Eyes: In case of eye contact, flush eyes with plenty of water for at least 15 minutes. Seek medical attention if irritation continues. Skin: If irritation devlops, discontinue use. Flush skin with copious amounts of water. Keep away from mucous membranes, broken or irritated skin. Ingestion: In case of ingestion, seek immediate medical attention or contact Poison Control Center. Inhalation: Remove from source of exposure. If signs of toxicity occur, seek immediate medical attention or contact Poison Control Center..." Review of the MSDS for Back To Basics Raspberry Almond Shampoo revealed "...Signs of Symptoms of Exposure: May cause nausea if ingested. May cause eye and skin irritation...Emergency and First Aid Procedures: If ingested, rinse mouth. Immediately give plenty of water. If appreciable quantities are swallowed,	F 323	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The CEO will report audit findings to the Quality Assurance Committee monthly for 3 months and PRN. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	Completed 10/22/12

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F 323	Continued From page 18 seek medical attention. In case contact with eyes or skin causes irritation, discontinue use and flush with water for 10 minutes. If discomfort persists, seek medical attention..." Review of the MSDS for barbicide revealed "...Health Hazards: Eyes: Burning sensation, watering, or redness...Inhalation: Prolonged inhalation exposure may cause nausea, dizziness or disorientation...Precautions for Safe Handling and Use, Handling: Avoid ingestion and eye contact. Storage: Keep out of reach of children..." Observation and interview on September 10, 2012, at 10:55 a.m., with the hairdresser confirmed the door to the beauty shop was open and unattended. Observation and interview on September 10, 2012, at 11:08 a.m., with the Administrator, in the beauty shop confirmed the beauty shop was to be locked when unattended and confirmed the beauty shop was unattended and unlocked.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of the manufacturer's information, and interview, the facility failed to prevent a significant medication error for one (#51) of thirty-four residents reviewed in Stage 2.	F 333	F333 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 51 had an order obtain to continue sliding scale on 9/11/12. Resident # 51 received insulin from backup pharmacy on 9/11/12 insulin was given with no negative outcomes noted.	

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F 333	Continued From page 19 The findings included: Resident #51 was admitted to the facility on October 13, 2006, with diagnoses including Diabetes and Schizophrenia. Observation on September 11, 2012, at 5:08 p.m, revealed Licensed Practical Nurse (LPN) #2 checked resident #51's blood sugar, with a result of 179. Interview on September 11, 2012, at 5:10 p.m., with LPN #2 revealed the resident was to receive Humalog insulin 2 units per sliding scale related to the blood sugar of 179, in addition to Humalog 10 units ordered to be administered with meals. Medical record review of the September 2012, physician's recapitulation orders revealed the resident was to receive Humalog insulin 10 units subcutaneously (by injection) with meals. Continued review of the September 2012, physician's recapitulation orders revealed no orders for the resident to receive sliding scale insulin. Medical record review of a Subcutaneous Sliding Scale Insulin Order Set, signed by the physician on March 26, 2012, revealed the resident was to have the blood glucose checked before meals and at hour of sleep, and if the blood sugar was 151 - 200 the resident was to receive 2 units of Humalog insulin. Observation and interview on September 11, 2012, from 5:15 p.m., until 5:30 p.m., revealed LPN #2 checked the medication cart and the	F 333	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** 100% review of all resident charts that receive sliding scale by the DON/ADON, and or Unit Managers to ensure physician orders for sliding scale are in place by 10/8/2012. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Unit Managers will complete audits weekly for four weeks and then monthly for two months of residents with sliding scale insulin to ensure the physician order is in place and insulin is available. Licensed nurses will be educated by the DON/ADON, Unit Manager, MDS nurse, or Night Supervisor on the correct procedure for ordering insulin by 9/24/12. Licensed nurses will be educated by the DON/ADON, Unit Manager, MDS nurse, or Night Supervisor on checking physician recapitulation orders to ensure all orders have been carried forward by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-services will be added to the orientation packet.	

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	445498	A. BUILDING _____ B. WING _____	09/12/2012

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F 333	Continued From page 20 medication room refrigerator for the Humalog insulin, and confirmed there was no Humalog insulin available for administration to resident #51. Observation on September 11, 2012, at 5:35 p.m., revealed the resident's supper meal was delivered to the resident. Observation on September 11, 2012, at 5:50 p.m., revealed the resident completed the supper meal. Observation on September 11, 2012, at 6:30 p.m., revealed the facility's consultant pharmacist delivered Humalog insulin, obtained from the facility's back-up pharmacy to LPN #2. Observation on September 11, 2012, at 6:35 p.m., (45 minutes after the resident completed the supper meal) revealed LPN #2 administered Humalog 12 units subcutaneously into the resident's right arm. Review of the manufacturer's information for Humalog revealed "...Humalog...is an injectable rapid-acting man-made insulin. Humalog is used to treat people with diabetes for control of high blood sugar...You should take Humalog within fifteen minutes before eating or right after eating a meal..." Interview on September 11, 2012, at 6:38 p.m., with the facility's consultant pharmacist confirmed Humalog insulin was to be administered within fifteen to twenty minutes of the meal.	F 333	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=F	Continued From page 21 INFORMATION	F 356		

The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to post nurse staffing data in a prominent place readily accessible to residents and visitors.

F 356

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

No residents were affected.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All resident had the potential to be affected.

Nursing staffing information was immediately posted by the Staff Coordinator on 9/10/12.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.

On 9/10/12 the staffing coordinator was in serviced by the DON on the need to post daily nursing staffing hours.

Starting on 9/24/12 the DON/ADON will monitor nursing staffing posting daily for two weeks and then weekly for two weeks and then monthly for two months to ensure the nursing staffing data is posted.

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F 356	Continued From page 22 The findings included: Observation on September 10, 2012, at 10:30 a.m., revealed the nurse staffing data was not posted. Interview on September 10, 2012, at 10:35 a.m., with the Scheduling Coordinator and the Administrator, at the nursing station confirmed the nurse staffing data was not posted.	F 356	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 3 months and PRN. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain dental services for one resident (#32) of thirty-four residents reviewed in Stage 2. The findings included: Resident #32 was admitted to the facility on May 23, 2006, with diagnoses including Gastrointestinal Hemmorrhage, Diabetes,	F 412	F 412 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 32 has a dental appointment scheduled for 10/2/12 by the Social Services Director. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All resident have the potential to be affected. 100% record review by Nursing Administration of dental assessments will be completed by 10/8/12 to ensure all assessments are current and accurate with care plan updated.	

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F 412	Continued From page 23 Chronic Airway Obstruction, Vascular Dementia, and Hypertension. Medical record review of the quarterly Minimum Data Set dated June 10, 2012, revealed the resident was able to make needs known, and understood what was said. Medical record review revealed no documentation the resident had received a dental consultation. Observation and interview on September 11, 2012, at 9:06 a.m., revealed the resident seated in a wheelchair in the dining room, and stated the dentures were too loose, "they worry me all the time," and would like to see a dentist. Observation with the Director of Nursing, on September 12, 2012, at 12:10 p.m., revealed the resident seated in a wheelchair in the dining room. Observation and interview with the resident, at this time, revealed the resident's dentures were too loose and sometimes caused problems with eating. Interview on September 12, 2012, at 1:55 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the resident had not received a dental consultation.	F 412	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON or Unit Managers will make weekly audits for four weeks and then PRN of dental assessment on all residents to ensure the assessments are completed correctly. Licensed staff will be educated by the DON/ADON, Uni Managers, MDS nurse, or Night Supervisor on completing dental assessments correctly by 9/28/12. Licensed nurses will be educated by the DON/ADON, Unit Managers, MDS nurse, or Night Supervisor on arranging dental services for any resident that appears to have concerns with their teeth or dentures by 9/28/12. CNAs will be educated by the DON/ADON, Unit Manager, MDS nurse, or Night Supervisor on communicating to the nurse with any and all resident concerns including dental concerns by 9/24/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-services will be added to the orientation packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 6 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general			

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F 425	Continued From page 24 supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide pharmacy services in a timely manner for one (#51) of thrity-four residents reviewed. The findings included: Resident #51 was admitted to the facility on October 13, 2006, with diagnoses including Diabetes and Schizophrenia. Observation on September 11, 2012, at 5:08 p.m, revealed Licensed Practical Nurse (LPN) #2 checked resident #51's blood sugar, with a result of 179. Interview on September 11, 2012, at 5:10 p.m., with LPN revealed the resident was to receive Humalog insulin 2 units per sliding scale related to the blood sugar of 179, in addition to Humalog	F 425	F 425 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 51 had an order obtain to continue sliding scale on 9/11/12. Resident # 51 received insulin from backup pharmacy on 9/11/12 insulin was given with no negative outcomes noted. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** 100% review of all resident charts that receive sliding scale by the DON/ADON, and Unit Managers to ensure physician orders for sliding scale are in place by 10/8/2012. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Unit Managers will complete chart audits of residents with sliding scale insulin to ensure the physician order is in place and insulin is available. Licensed nurses will be educated by the DON/ADON, Unit Managers, MDS nurse, or Night Supervisor on the correct procedure for ordering insulin and transcribing the Physician order by 9/24/12.	

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F 425	Continued From page 25 10 units ordered to be administered with meals. Medical record review of the September 2012, physician's recapitulation orders revealed the resident was to receive Humalog insulin 10 units subcutaneously (by injection) with meals. Medical record review of a Subcutaneous Sliding Scale Insulin Order Set, signed by the physician on March 26, 2012, revealed the resident was to have the blood glucose checked before meals and at hour of sleep, and if the blood sugar was 151 - 200 the resident was to receive 2 units of Humalog insulin. Observation and interview on September 11, 2012, from 5:15 p.m., until 5:30 p.m., revealed LPN #2 checked the medication cart and the medication room refrigerator for the Humalog insulin, and confirmed there was no Humalog insulin available for administration to resident #51. Observation on September 11, 2012, at 6:30 p.m., revealed the facility's consultant pharmacist delivered Humalog insulin, obtained from the facility's back-up pharmacy to LPN #2. Observation on September 11, 2012, at 6:35 p.m., (45 minutes after the resident completed the supper meal) revealed LPN #2 administered Humalog 12 units subcutaneously into the resident's right arm. Review of the manufacturer's information for Humalog revealed "...Humalog...is an injectable rapid-acting man-made insulin. Humalog is used to treat people with diabetes for control of high	F 425	Licensed nurses will be educated by the DON/ADON, Unit Managers, MDS nurse, or Night Supervisor on checking physician recapitulation orders to ensure all orders have been carried forward by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-services will be added to the orientation packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12

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F 425	Continued From page 26 blood sugar...You should take Humalog within fifteen minutes before eating or right after eating a meal..." Interview on September 11, 2012, at 6:38 p.m., with the facility's consultant pharmacist revealed Humalog insulin was to be administered within fifteen to twenty minutes of the meal.			
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	F 431 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents with orders for finger sticks have the potential to be affected. Undated glucose strips on med carts were removed and replaced with glucose test strips that were dated correctly on 9/11/12 by the hall nurses. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Units managers will complete weekly audits for two weeks and then monthly for two months of med carts to ensure that glucose bottles are dated when opened. Licensed nurses will be educated by the DON/ADON, Unit Managers, MDS nurse, or Night Supervisor on dating glucose strips when opened by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-services will be added to the orientation packet.	

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F 431	Continued From page 27 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interview, the facility failed to ensure proper and safe storage of drugs and biologicals in three of the four medication carts observed. The findings included: Observation of the long hall medication cart on September 11, 2012, at 4:15 p.m., with Licensed Practical Nurse (LPN) #5 in the First Tennessee medication room, revealed one bottle of thirty-five glucose test strips opened and undated. Review of facility policy entitled Labeling of Medication Containers revealed..."Labels for each floor's stock medications shall include all necessary information, such as...the expiration date when applicable." Interview with LPN #5, on September 11, 2012 at 4:15 p.m., confirmed the bottle of the glucose test strips had not been dated. Observation of the short hall medication cart on September 11, 2012, at 6:10 p.m., with LPN #3, in the Second Tennessee medication room revealed a bottle of four glucose test strips opened and undated.	F 431	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 3 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12

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F 431	Continued From page 28 Interview with LPN #3, on September 11, 2012, at 6:10 p.m., in the Second Tennessee medication room confirmed the bottle of the glucose test strips were opened and undated. Observation of the long hall medication cart on September 11, 2012, at 6:20 p.m., with LPN #1, in the Second Tennessee medication room revealed a bottle of thirteen glucose test strips opened and undated. Interview with the Director of Nursing on September 12, 2012, at 8:00 a.m., in the conference room confirmed the facility failed to properly label and store the blood glucose strips.	F 431		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to adequately furnish a designated dining area to accommodate resident needs for 12 residents (#57,#31,#29,#135,#112, #25, #24, #136, #105, #39 #94, #23) in one of two dining rooms. Observation on September 10, 2012, from 12:17p.m. through 1:10p.m., in the second floor	F 464	F 464 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 9/10/12 extra tables were brought into the dinning room to accommodate resident's needs by maintenance. No negative outcomes noted thru observation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Starting on 9/24/12 "All Hands on Deck" department heads will be assigned units to assist in passing trays out and set up when available.	

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F 464	Continued From page 29 dayroom, revealed the room was inadequately furnished to accommodate the needs of residents who regularly dine in this area. Twelve residents were present at the time of the observation. Two of the residents were ambulatory with walkers, the others were propelling in wheelchairs, or reclined in geri-chairs. The room was furnished with only three tables, one eight seat table, and two four seat tables. At no time during the 53 minute dining observation were more than four residents seated at any of the tables (including the large table) and four of the residents (#29, #57, #112, #23) were fed from bedside tables while seated in their geri-chairs. One resident (#94) had to wait for other residents to finish their meal until a bedside table became available to hold the meal tray. This resident waited 40 minutes after the trays arrived on the floor to begin eating the meal. Interview with LPN # 3, at the time of the observation, revealed the furnishings were sparse and insufficient to allow the residents to dine comfortably and simultaneously. Interview with the Administrator, September 10, 2012, at 12:55, in the second floor dayroom, at the time of the observation, confirmed the furnishings were inadequate to accommodate the residents' dining needs.	F 464	**What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the Unit Managers will monitor meal services daily for two weeks and then weekly for four weeks and then PRN to ensure correct dinning procedures and resident dignity during dinning are being followed. The DON/ADON, Unit Manager, MDS Nurse, or Night Supervisor will educate the nursing staff on correct dinning procedures and resident dignity during dinning by 9/28/2012. Starting after 9/28/12 staff will be in serviced on the process for meal services to ensure meals are served timely prior to being allowed to return to the floor. In-service will be added to the orientation packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 6 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	09/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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F 500	Continued From page 30 arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure communication between the facility and the dialysis center for one resident #123 of thirty-four residents reviewed in stage 2. The findings revealed: Resident #123 was admitted to the facility on June 20, 2012, with diagnosis including Chronic Kidney Disease, Diabetes Mellitus, Congestive Heart Failure, and Hyperlipidemia. Medical record review of the resident care plan dated July 6, 2012, revealed "...Dialysis 3(three) times a week..." Continued record review revealed no documentation between the dialysis center and the facility to communicate the resident care before or after receiving a dialysis treatment. Interview and medial record review with the	F 500	F 500 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident # 123 had information obtained from the dialysis center on 9/14/12 by DON. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** 100% audit of all resident charts with dialysis will be completed done to ensure dialysis information has been obtained by 9/24/12. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not occur.** Starting on 9/24/12 the DON/ADON will make audit checks of patient charts with dialysis to ensure communication is being provided. Licensed nurses will be educated by the DON/ADON, Unit Manager, MDS nurse, or Night Supervisor on provide communication to and following up with the dialysis center if resident returns without any information provided by 9/28/12. Starting after 9/28/12 staff will be in serviced prior to being allowed to return to the floor. In-service will be added to the orientation packet.	

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F 500	Continued From page 31 Director of Nursing (DON) on September 12, 2012, at 3:45 p.m., in the first floor dining room, confirmed the facility failed to ensure communication with the dialysis center.	F 500	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly for 6 months. The Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Manager, Social Services Director, Maintenance Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	completed 10/22/12